United States Court of Appeals

for the Second Circuit

APPELLANT'S BRIEF

NO. 75-6136

IN THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

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SOUTH WINDSOR CONVALESCENT HOME, INC.,

Plaintiff-Appellee,

v.

DAVID MATHEWS, Secretary of Health,
Education and Welfare, et al.,

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT
COURT FOR THE DISTRICT OF CONNECTICUT

BRIEF FOR THE DEFENDANTS-APPELLANTS

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I N D E X

CITATIONS

Cases:

Miscellaneous:

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QUESTIONS PRESENTED

1. Whether the district court possessed jurisdiction.

2. Whether a regulation promulgated by the Secretary of Health, Education and Welfare, 20 C.F.R. 405.415(d)(3), providing for the recapture of accelerated depreciation from a provider of services which leaves the Medicare program, may lawfully be applied so as to recapture funds received by the provider prior to the first day of the year in which the regulation became effective.

STATEMENT

1. Nature of the case. Plaintiff, South Windsor Convalescent Home, Inc. ("South Windsor") instituted this suit against the United States, the Secretary of Health,

Education, and Welfare ("Secretary") and the Secretary's agents, Travelers Insurance Company, seeking to recover a sum paid to these defendants on account of the receipt by the plaintiff of an alleged overpayment under the Medicare Act, 42 U.S.C. 1395 et seq., on the grounds that the regulation which resulted in the alleged overpayment could not be lawfully applied to the years in question.

The district court held that the defendants could not lawfully apply the regulation to years prior to the first day of the year in which the regulation became effective and entered judgment in favor of the plaintiff in the amount of $15,055.00.

The defendants appeal.

2. The Medicare program.[1/] The "Medicare" provisions of the Social Security Act were first enacted as part of the Social Security Act Amendments of 1965, P. L. 89-97, July 30, 1965 and now constitute Title XVIII of the Social Security Act. 42 U.S.C. 1395 et seq.

The Medicare provisions are divided into two parts, Part A, 42 U.S.C. 1395c-1395i-2 (1970) (Supp. III) and Part B, 42 U.S.C. 1395j-1395w (1970) (Supp. III). Part A, the only part involved here, is designed to provide "basic protection against the costs of hospital and related post-hospital services . . . for individuals who are aged 65 or over"[2/] by providing for government payment (after payment of a

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1/ The Medicare Act was amended in various respects in 1972. See 42 U.S.C. 1395 et seq. (1970) (Supp. III). These Amendments are referred to only where relevant to this case.

2/ 42 U.S.C. 1395c.

deductible by the beneficiary)[3] of the "reasonable cost" of certain defined basic services[4] which are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member".[5]

Participation by a "provider of services", i.e., a hospital, extended care facility, or home health agency,[6] such as Windsor, is voluntary and a provider which desires to terminate its participation may do so upon notice to the Secretary.[7]

So long as a provider participates in the program, it must adhere to its agreement with the Secretary not to charge a patient for items or services for which payment is made by the Government under the Medicare program. 42 U.S.C. 1395cc (a)(1)(A). Thus, providers of services are not paid by patients covered by the Medicare program. They are, instead, reimbursed by the Secretary from the Federal Hospital Insurance Trust Fund, which is in turn financed by special wage taxes,[8] on the basis of the reasonable cost incurred in rendering services to those patients.

The Medicare Act does not define the term "reasonable cost", 42 U.S.C. 1395x(u). Rather, the "reasonable cost"

3/ 42 U.S.C. 1395e.

4/ See 42 U.S.C. 1305d.

5/ 42 U.S.C. 1395y(a)(1).

6/ 42 U.S.C. 1395x(u).

7/ 20 C.F.R. sec. 405.613.

8/ 42 U.S.C. 1395i.

of any service is to be determined in accordance with regulations promulgated by the Secretary establishing the method or methods to be used and the items to be included in determining those costs. The Act specifically provides that these regulations must provide "for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. 1395x(v)(1)(B).

A provider is reimbursed on an interim, pre-audit basis not less often than monthly, 42 U.S.C. 1395g, based upon billings submitted to the Secretary which are preliminarily determined by the latter to certain charges for the "reasonable cost" of providing services covered under the Act to Medicare beneficiaries. Ibid. At the close of the provider's fiscal year, it submits a cost report, and the Secretary then determines by audit the actual amount of reimbursement to which the provider is entitled for that year. 20 C.F.R. 405.451(b)(1). If it is determined at the final audit that the interim payments were more or less than the amount to which the provider is entitled under the cost report, an adjustment may be made in the current interim payment to the provider in order to recoup or repay the difference between the total interim payments during the fiscal year and the amount determined to be due as a result of the audit of the cost report. 42 U.S.C. 1395g; 20 C.F.R. 405.454.

A basic feature of the Medicare program is the fact that it is administered in substantial part, by private organiza-

tions under contract with the Secretary. Pursuant to 42 U.S.C. 1395h, a provider of services, such as Windsor, may nominate a private organization, such as Travelers here, to act as a "fiscal intermediary". If a provider nominates a fiscal intermediary and the intermediary enters into an agreement with the Secretary containing certain specified terms and conditions, the providers which nominated the intermediary submit their bills for services to the latter which is responsible for their payment as agent for the Secretary. 42 U.S.C. 1395h(a). The intermediary may also serve as the Secretary's agent for such matters as the dissemination of information, the audit for providers, and "such other functions as are necessary" in order to implement the Act. Ibid.

3. This litigation. The regulations of the Secretary defining "reasonable cost" have always recognized that capital assets are consumed in the course of rendering services to Medicare beneficiaries. Accordingly, the Secretary's regulations have always provided for the inclusion of an allowance for depreciation of assets utilized in rendering these services as a part of the cost for which a provider is reimbursed under the program. See, e.g. 20 C.F.R. 405.415 (1967).

Prior to August 1, 1970, providers were entitled to compute depreciation charges by means of either the "straight-line" or the "accelerated" method, See 20 C.F.R. 405.415 (1970). On August 1, 1970 a new regulation first

proposed by the Secretary on February 5, 1970, [9] became effective. [10] This regulation, now 20 C.F.R. 405.415(d)(3), provided, inter alia, that the accelerated method of depreciation could not be utilized by providers who entered the program after its effective date. In addition, the regulation stated that if a provider which had been utilizing the accelerated method of depreciation terminated its participation in the program after the effective date of the regulation, the difference between the reimbursement received by the provider, utilizing the accelerated method, and what it would have received had it utilized the "straight-line" method would be recouped as an overpayment received by the provider during its participation in the program. 20 C.F.R. 405.415(d)(3).

Windsor was a provider of skilled nursing services under the Medicare program between July 1, 1967 and October 1, 1971. App. 14a-15a. During this period, it was reimbursed for the depreciation, calculated by means of the accelerated method, of certain assets utilized in the course of rendering services to Medicare beneficiaries.

On July 12, 1972, Windsor's intermediary, acting pursuant to 20 C.F.R. 405.415(d)(3), requested Windsor to repay, less certain adjustments, the difference between the reimbursement Windsor received utilizing the accelerated method of depreciation and what it would have received had it utilized

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9/ 35 Fed. Reg. 2593.

10/ 35 Fed. Reg. 12330.

the accelerated method of calculation for Windsor's fiscal years ending September 30, 1967 through September 30, 1971. Plaintiff paid the amount due and then instituted this suit claiming that the Secretary could not lawfully apply the regulation to the years in issue. App. 3a-13a.

The district court granted judgment for Windsor. After noting that the Secretary's original regulation did not reserve the right to recapture depreciation in excess of that calculated by means of the straight-line method, App. 28a-29a, the court, "following the principle applied in tax cases", App. 30a, held that the regulation could not be constitutionally applied prior to the first day of the year, 1970, in which the regulation first became effective:

> "This Court, following the principle applied in tax cases, finds that Medicare regulation 20 C.F.R. sec. 405.415(d)(3) is unconstitutional as applied to the plaintiff. The amended regulation seeks to recapture reimbursement for accelerated depreciation charges, which were authorized and lawfully taken prior to the commencement of the calendar year in which the regulation was adopted and promulgated. Since the effective date of the regulation was August 1, 1970, (sec. 405.415(h)), the Court finds that the accrued charges which were recouped by the defendants for the period prior to January 1, 1970, are unconstitutional, under the due process clause of the fifth amendment to the United States Constitution. See, Hazelwood Chronic and Convalescent Hospital v. Weinberger, Civil No. 73-210 (D. Oregon, March 26, 1974)."

App. 30a-31a. The court thereupon entered judgment for Windsor in the amount of $15,655.00. App. 32a.

The defendants appeal.

STATUTES AND REGULATIONS INVOLVED

42 U.S.C. 1395ii provides:

> The provisions of sections 406 and 416(j) of this title, and of subsections (a), (d), (e), (f), (h), (i), (j), (k), and (l) of section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter.

42 U.S.C. 405(h) provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or government agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this subchapter.

42 U.S.C. 1395g provides:

> The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

42 U.S.C. 1395x(v)(1) provides:

> The reasonable cost of any services shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; . . . Such regulations shall (A) take into account both direct and indirect costs or providers of services in order that, under the methods of determining costs, the costs with respect to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, . . . and (B) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive . . .

20 C.F.R. 405.415(d)(3) provides:

> When a provider who has used an accelerated method of depreciation with respect to any of its assets terminates participation in the program, or where the health insurance proportion of its allowable costs decreases so that cumulatively substantially more depreciation was paid than would have been paid using the straight-line method of depreciation, the excess of reimbursable cost, determined by using accelerated depreciation methods and paid under the program over the reimbursable cost which would have been determined and paid under the program by using the straight-line method of depreciation will be recovered as an offset to current reimbursement due or, if the provider has terminated participation in the program, as an overpayment. In this determination of excess payment, recognition will be given to the effects the adjustment to straight-line depreciation would have on the return on equity captial and on the allowance in lieu of specific recognition of other costs . . . .

ARGUMENT

We demonstrate in Point I that the district court lacked jurisdiction to entertain this suit. The Medicare Act expressly incorporates 42 U.S.C. 405(h) and, pursuant to this provision, 42 U.S.C. 405(g) provides the sole jurisdictional base for a suit against the Secretary. Weinberger v. Salfi, 422 U.S. 749 (1975). Since 42 U.S.C. 405(g) is not applicable here, the district court lacked jurisdiction. In any event, since this is a suit for a money judgment in which more than $10,000 is in controversy, if jurisdiction over this suit does exist, it lies only in the Court of Claims. 28 U.S.C. 1491; 28 U.S.C. 1346(a)(2).

We demonstrate in Point II that, assuming the district court possessed jurisdiction, the regulation was authorized by statute, is reasonable, and that its application to the years in question is constitutional.

I.

THE DISTRICT COURT LACKED JURISDICTION TO ENTERTAIN THIS SUIT.

In its complaint (App. 3a), South Windsor alleges jurisdiction pursuant to 28 U.S.C. 1331. However, as we now show, jurisdiction was not conferred upon the district court by this statute, the Administrative Procedure Act ("APA"), 5 U.S.C. 701, et seq. or 28 U.S.C. 1361, and the court should have dismissed the complaint for that reason. See Weinberger

v. Salfi, 422 U.S. 749 (1975). Indeed, the Congress has expressly precluded judicial review here. We also demonstrate in Point B that if jurisdiction over this suit does exist in any court, it lies only in the the Court of Claims.

A. The District Court Lacked Jurisidiction Pursuant to 28 U.S.C. 1331, the APA, and 28 U.S.C. 1361.

1. 28 U.S.C. 1331. The Medicare Act, expressly incorporates 42 U.S.C. 405(h).[11/] This section provides:

> [1] The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. [2] No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal or Government agency except as herein provided. [3] No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this subchapter.

It is clear that the third sentence of this section deprives the Federal courts of jurisdiction pursuant to 28 U.S.C. 1331 on any claim arising under the Medicare Act. Weinberger v. Salfi, 422 U.S. 749, 757-59 (1975). Since Windsor's claim would not exist but for the Social Security Act, its claim arises under that Act even though premised

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11/ 42 U.S.C. 1395ii provides: "The provisions of sections 406 and 416(j) of this title, and of subsections (a), (d), (e), (f), (h), (i), (j), (k), and (l) of section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter."

upon the Constitution, id. at 760-61, and jurisdiction to entertain this suit pursuant to 28 U.S.C. 1331 is clearly foreclosed.

To the extent that this Court's decision in Kingsbrook Jewish Medical Center v. Richardson, 486 F. 2d 663, 667 (C.A. 2, 1973) is to the contrary, the reasoning of that decision has been disapproved by the Court in Salfi. In Kingsbrook, this Court held that where the Medicare Act establishes procedures for review of the Secretary's decision, those procedures are exclusive. 486 F. 2d at 666-67. However, according to the Court, where no method of review is set forth in the Act, "all of the restraints on judicial action included in section 405(h)," including those contained in the third sentence are inapplicable. Id. at 667 (emphasis in the original).

However, this reasoning concerning the third sentence of section 405(h) renders the first two sentences virtually meaningless. As the Supreme Court noted in Salfi, it is the first two sentences of sec. 405(h) ". . . [which] prevent review of decisions of the Secretary save as provided in the Act . . . ." 42 U.S. at 757. The simple fact is, as the Supreme Court also noted, the third sentence of sec. 405(h) is "plain from its own language which is sweeping and direct and which states that no action shall be brought under sec. 1331." Ibid (emphasis in original).

2. The APA. The status of the APA in this Circuit as an independent basis for jurisdiction is subject to some doubt. See Aguayo v. Richardson, 473 F. 2d 1090 (C.A. 2,

1973), certiorari denied, 414 U.S. 1146 (1974). Nevertheless, it is clear that even if the APA is an independent grant of jurisdiction, it is not applicable here.

By its express terms, the APA does not apply in circumstances where a statute precludes judicial review, 5 U.S.C. 701, and it is clear that judicial review in this case is precluded by the Social Security Act.

For purposes of this suit,[12/] 42 U.S.C. 1395ff(c) provides that:

> Any institution or agency disatisfied with any determination by the Secretary that it is not a provider of services, or with any determination [by the Secretary to the effect that a provider may no longer participate in the program] shall be entitled to a hearing thereon by the Secretary . . . to the same extent as provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as provided in section 405(g) of this title.

This provision renders section 405(g) inapplicable to disputes by a provider concerning the amount of reimbursement which it receives under Part A. This fact, coupled with the incorporation of section 405(h) into the Medicare Act -- a section which renders judicial review available only under Section 405(g) -- makes it clear that judicial review of a dispute between a provider and the Secretary concerning the amount of reimbursement due the former is precluded. The beneficiary is the sole party permitted to obtain judicial

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12/ The Act was amended in 1972 to provide for judicial review in circumstances not relevant here.

review of the amount of reimbursement due under Part A, 42 U.S.C. 1395ff(b), and then only if the amount in controversy exceeds $1,000.[13/] Ibid. The only review available to the provider in these circumstances is the review by the intermediary which is specified in the agreement between the Secretary and the intermediary pursuant to 42 U.S.C. 1395h(a) (1970).

This principle is made clear by the fact that in 1972, Congress amended the Meidcare Act so as to establish a Provider Reimbursement Review Board to determine controversies between a provider and an intermediary concerning the amount of reimbursement due a provider. 42 U.S.C. 1395oo (1970) (Supp. III).[14/] Judicial review of decisions of the Board is available to a provider "under chapter 7 of Title 5, notwithstanding any other provision of section 405 of this title." 42 U.S.C. 1395oo(g) (1970) (Supp. III). Obviously, the last quoted phrase would have been unnecessary had Congress believed that section 405 did not in fact preclude review under the APA.

13/ For certain fiscal years not relevant here, where the Secretary determines that an overpayment was made because services were rendered which were not covered under the Act, and the provider knew or could have been expected to know that the services were subject to reimbursement under Part A, the provider or physician succeeds to the right of the beneficiary to judicial review after the Secretary determines that the beneficiary will not exercise his right to judicial review. 42 U.S.C. 1395pp(d) (1970) (Supp. III).

14/ The amendment is effective only for accounting periods ending on or after June 30, 197[illegible]. 42 U.S.C. 1395oo note (1970) (Supp. III).

To the extent the decision of this Court in Aquavella v. Richardson, 437 F. 2d 397 (C.A. 2, 1971)[15/] is to the contrary the reasoning of that decison was disapproved in Salfi. The APA was expressly alleged as a jurisdictional basis in Salfi[16/] and yet the Court dismissed the suit as to any parties other than the named plaintiffs, on the ground that sources of jurisdiction other than 405(g), were precluded by 405(h). 422 U.S. at 764. Since 405(h), but not 405(g), is applicable here, jurisdiction pursuant to the APA is not present.

Finally, we note that the APA is not a source of jurisdiction for yet another reason. The only relief requested by Windsor in its complaint is a "judgment in its favor in the amount of $34,324.00 plus interest and costs." App. It is well-settled that nothing in the APA authorizes a court to compel the payment of funds by the Government. 5 U.S.C. sec. 206. See Blackmar v. Guerre, 342 U.S. 512, 515-516 (1952); Zimmerman v. United States Government, 422 F. 2d 326 (C.A. 3), certiorari denied, 399 U.S. 911 (1970); Chournas v. United States, 355 F. 2d 919 (C.A. 10, 1964). Thus, even if the APA could apply notwithstanding section 405(h), the APA does not apply here.

3. 28 U.S.C. 1361. It is also clear that notwithstanding the pre-Salfi decisions of this Court in such cases as Frost v. Weinberger, 515 F. 2d 57 (C.A. 2, 1975), petition for certiorari

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15/ See also, Rothman v. Hospital Service of Southern California, 510 F. 2d 596 (C.A. 9, 1975).

16/ Complaint, sec. 1, Salfi v. Weinberger, N.D. Cal., No. 73-1863.

pending, Sup. Ct. No. 75-1041, jurisdiction in this case does not lie under the mandamus statute. 28 U.S.C. 1361. Jurisdiction pursuant to 28 U.S.C. 1361 was alleged in Salfi.[17/] Yet, again, the Court held that sources of jurisdiction other than sec. 405(g) are foreclosed by sec. 405(h). 422 U.S. at 264. Thus, jurisdiction pursuant to 28 U.S.C. 1361 is not present here.

In any event, as we have noted, the sole relief requested by Windsor is a money judgment. Mandamus, which is available only to compel an administrative official to perform a ministerial task, Wilbur v. United States, 281 U.S. 206, 218 (1930), cannot be utilized to compel the payment of Government funds. See Mine Safety Appliances Co. v. Forrestal, 326 U.S. 371 (1945). Rose v. McNamara, 225 F. Supp. 891 (E.D. Va. 1963); Rothgeb v. Staats, 59 F.R.D. 559 (S.D. Ohio, 1972).

B. Alternatively, the Court of Claims Possesses Exclusive Jurisdiction To Entertain This Suit.

Even if the jurisdictional bar represented by section 405(h) were not present here, it is clear that the district court should have dismissed this suit. Mine Safety Appliance Co. v. Forrestal, supra.

The only relief requested by Windsor in its complaint was a money judgment in excess of $34,000, App. 13a, and the only relief awarded by the district court was a money judgment in the amount of $15,655.00 App. 32a. Yet, 28 U.S.C. 1346 provides that the district courts possess jurisdiction,

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17/ Complaint, sec. 1, Salfi v. Weinberger, N.D. Cal., No. 73-1863.

concurrent with the Court of Claims, to entertain claims against the United States only so long as those claim do not exceed $10,000. 28 U.S.C. 1346(a)(2). Any claim in excess of this amount must be recovered by means of a suit only in the Court of Claims. 28 U.S.C. 1491. Under these circumstances, it is clear that the Court of Claims possesses exclusive jurisdiction to entertain this suit, and the district court should have dismissed this complaint.[18/]

II.

EVEN IF THE DISTRICT COURT POSSESSED JURISDICTION, IT ERRED IN HOLDING THAT THE REGULATION COULD NOT BE CONSTITUTIONALLY APPLIED TO THE PERIOD IN QUESTION

We demonstrated in Point I that the district court lacked jurisdiction to entertain this suit. We now demonstrate that the judgment of the district court should be reversed even if it possessed jurisdiction. The regulation is authorized by statute and is reasonable. The application of the regulation to periods prior to the first day of the year in which it became effective is not so harsh and oppressive as to violate the Constitution.

18/ Windsor at least implicitly recognized that the true nature of this suit since it joined the United States as a defendant. The United States is an indispensible party in a suit of this type, see Mine Safety Appliance Co. v. Forrestal, supra, and the presence of the United States as a defendant further supports the fact that the Court of Claims possesses exclusive jurisdiction here.

A. The regulation is authorized by the Act and is reasonably designed to accomplish the purpose of the Act.

1. General background.

The passage of the Medicare Act by Congress was considered to be an historic event. See, e.g., 111 Cong. Rec. 15800 (remarks of Senator Javits); 15801 (remarks of Senator Ribicoff); 15812 (remarks of Senator Hart); 15837 (remarks of Senator Smathers); 15879 (remarks of Senator Fong). For the first time, the federal government has assumed responsibility for providing basic protection against the cost of hospital and related post-hospital services for individuals 65 and older. 42 U.S.C. 1395c.

Although a program of this nature had been discussed for some time, see Sundquist, Politics and Policy: The Eisenhower, Kennedy and Johnson Years 290 (1968), the enactment of legislation had been long delayed. One of the reaons for this delay was the absence of agreement on the method for determining the reimbursement to be made by the government for services rendered to beneficiaries of the program. As the Senate report on the bill which became the Act noted: "The appropriate basis of payment for hospital services when payment is made by public or private agencies has been the subject of extended and painstaking debate for more than a decade." S. Rep. No. 404, 1965, U.S. Code Cong. & Ad. News 1943, 1976 (89th Cong., 1st Sess.) (Hereinafter "S. Rep. No. 404").

One of the reasons for the lack of agreement on the issue was the varying methods utilized by providers in determining

patient charges. See S. Rep. No. 404, at 1976-77. For example, some providers based their charges on average patent cost per day while others based charges on very detailed accounting records as to actual cost. Ibid. No agreement on the proper method was apparent.

In light of this fact, Congress decided not to specify in the statute the method to be utilized to determine the reimbursement due a provider under Medicare. Rather, Congress merely established certain general principles and authorized the Secretary to establish the details. Thus, 42 U.S.C. 1395f(b) specifies that providers are to be reimbursed for the "reasonable cost" of services rendered to Medicare beneficiaries, and 42 U.S.C. 1395x(v) [19/] provides that the Secretary is to define "reasonable cost" as follows:

> (1) The reasonable cost of any services shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included . . . .
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> * * * * *
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> Such regulation may provide for determination of the costs of services on a per diem, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, and may provide for the use of charges or a percentage of charges where the method reasonably reflects the costs. Such regulations shall (A) take into account both direct and indirect costs of providers of services in order that,

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19/ In 1972 Congress amended this section so as to change the designation of the subparagraphs. 42 U.S.C. 1395x(v) (1970) (Supp. II). No change in substance was made in the relevant section, however. The quotation in the text is from the section prior to the 1972 amendment.

> under the methods of determining costs, the costs with respect to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (B) provide for the making of suitable retroactive corrective adjustments where for a provider of services for any fiscal period, the agrregate reimbursment produced by the methods of determining costs proves to be either inadequate or excessive.

It is clear from this provision that the Secretary is granted broad latitude in prescribing the method or methods for determining "reasonable cost" under the statute. See also 42 U.S.C. 1395hh. Nevertheless, he is required to be guided by one basic principle. As the Senate report on the bill which became the Medicare Act stated:

> Although payment may be made on various bases the objective, whatever method of computation is used, will be to approximate as closely as practicable the actual cost (both direct and indirect) of services so that under any method of determining costs, the costs of services of individuals covered by the program will not be borne by individuals not covered, and the costs of services to individuals not covered will not be borne by the program. [S.Rep. No. 404, supra, at 1976. See also, 42 U.S.C. 1395x (v)(1)(B).

Thus, the Secretary is required to focus upon the actual cost of rendering services only to beneficiaries. Whenever he determines that a method of determining those costs which he has specified results in inadequate reimbursement to providers or results in overpayments to them, he is required to make "suitable retroactive corrective adjustments" to rectify the situation. Kingsbrook Jewish Medical Center v. Richardson, supra.

In promulgating regulations defining the method of determining reasonable cost, the Secretary has always recognized that depreciation represents a cost of service. E.g., 20 C.F.R. 405.415 (1967). This was only reasonable since captial is consumed in the production or rendering of those services, [20/] and the Secretary was required, as noted above, to reimburse providers for the "actual cost" (which would include the cost of capital consumed) of providing services to Medicare beneficiaries.

Once it was determined that providers participating in the Medicare program were to be reimbursed for the capital consumed in providing services to beneficiaries, it became necessary to decide upon a method of measuring the cost of the consumed capital in a rational and systematic manner.

For a considerable period of time, the most generally accepted method of measuring the cost of capital consumed in a business involved an even allocation of the cost of the asset, less its salvage value, over its useful life. See, e.g., H. Rep. No. 1337, p. 22 (83d Cong., 2d Sess.). This method, known as the "straight-line method," provided (and still provides) a method of allocating the actual cost of a capital asset to each year in which it is used to produce revenue and was the primary method used for purposes of income taxation until 1954. Ibid.

20/ See Reimbursement Guidelines for Medicare, Hearing before the Senate Committee on Finance, p. 47 (89th Cong., 2d Sess.) (hereinafter referred to as "Hearings").

In his budget message for fiscal year 1955, President Eisenhower proposed that Congress amend the Internal Revenue Code so as to permit taxpayers to utilize accelerated methods of depreciation in determining the amount of the deduction from gross income permitted each year for the exhaustion and consumption of property used in a trade or business. 1954 U.S. Code, Cong. & Ad. News, pp. 1557, 1556-67 (83d Cong., 2d Sess.). These accelerated methods would permit taxpayers to allocate more of the cost of a capital asset to the early years of its useful life rather than requiring the allocation of the same amount in each year of the unseful life. Ibid. The President made this proposal not simply because the accelerated methods more accurately measured the consumption or utilization of the assets but because the use of these accelerated methods would stimulate new investment. Ibid.

The President's proposal was enacted into law in hopes that it would indeed stimulate new investment. See H. Rep. No. 1337, p. 22 (83d Cong., 2d Sess.). In theory, the use of accelerated depreciation would operate as planned. Depreciation charges were (and are) subtracted from gross income in order to determine taxable income. 26 U.S.C. 107. The larger the depreciation charge, therefore, the lower the taxable income and, hence, the lower the taxes. The theory was that, if businessmen were permitted greater initial depreciation charges, they would invest in capital assets, since to do so would in the short term reduce their taxable income while a failure to invest would simply mean that most of what they

would have invested would be paid to the government in the form of taxes.

Similar considerations affected the Secretary in the beginning years of the Medicare program in determining which method or methods of depreciation providers would be permitted to utilize in determining the cost of providing service to Medicare beneficiaries. As noted above, the straight-line method of depreciation was and is generally accepted as a means of accurately reflecting the cost of capital consumed in the production of income. Certainly, the Secretary possessed the authority to so decide. 42 U.S.C. 1395x(v). Accordingly, the Medicare regulations from the beginning have permitted the use of straight-line depreciation. E.g., 20 C.F.R. 405.415 (1967). However, the Secretary at that time believed that if providers were to be permitted to utilize only the straight-line method many providers would not initially receive reimbursement in amounts which would be sufficient to meet the mortgage payments on the assets or to effectively assist in meeting replacement costs. Hearings, supra, fn. 11, p. 47. Accordingly, he also decided to permit providers, at their option, to utilize either the straight-line method or one of two accelerated methods of depreciation in determining the cost of capital consumed in the course of providing services to Medicare beneficiaries. Ibid. See 20 C.F.R. 405.415 (1967).[21/]

21/ Indeed, today the regulations continue to authorize the use of an accelerated method of calculating depreciation where a provider would experience a cash-flow problem if permitted to utilize only the straight-line method of calculation. 20 C.F.R. 405.415(a)(3)(iii).

In effect, the reasoning behind the Secretary's decision to permit the use of an accelerated method of depreciation was similar to the reasoning which was behind the decision to permit the use of accelerated depreciation for income tax purposes. The use of accelerated depreciaiton for the latter, as noted above, was intended to induce businessmen to invest in capital assets since to do so would result in a short-term reduction of taxable income. This could be accomplished, as President Eisenhower noted, without increasing total deductions. 1954 U.S. Code, Cong. & Ad. News, supra, at p. 1567. Similarly, the use of accelerated depreciaiton as a factor in determining the cost of providing services to Medicare beneficiaries would result in greater reimbursement to providers in the early years of the useful life of an asset (since greater depreciation charges meant greater costs chargeable to the program), but, so long as the provider remained in the program, no ultimate increase in reimbursement.

The Secretary could accomplish his purpose, as the chart regulating a hypothetical case attached as addendum to this brief so graphically illustrates, so long as the provider remained in the program. If, however, a provider utilizes an accelerated method of depreciation and if it leaves the program before the termination of the useful life of the asset, it will receive a greater total reimbursement than it would have received had it utilized the straight-line method of depreciation for the same period. The regulation at issue is designed in part to remedy the difficulty caused

by this fact in the same manner as amendments to the Internal Revenue Code (designed to recapture accelerated depreciation) were adopted subsequent to the provisions permitting the use of accelerated depreciation in order to prevent tax abuses of that calculation method. See e.g., 26 U.S.C. sec. 1250.

2. The Secretary's 1970 regulations. At some point prior to February 5, 1970, the Secretary determined that the use of accelerated methods of depreciation was resulting in excessive payments to some providers. Accordingly, on February 5, 1970, he published proposed regulations in the Federal Register, 35 Fed. Reg. 2593 (now 20 C.F.R. 405.415 (d)(3)), which were designed to, inter alia:

> (a) permit providers participating in the program to continue to utilize an accelerated method of depreciaiton so long as they remained in the program;
>
> (b) permit recovery, as overpayments, of those sums received by a provider which utilized an accelerated method of depreciation and which terminated its participation in the program prior to the expiration of the useful life of the asset, which exceeded the sums it would have received had it utilized the straight-line method during the period of its participation;
>
> (c) prohibited the use of accelerated depreciation (except in certain limited circumstances) by providers entering the program for the first time.

This regulation became effective nearly six months later, on August 1, 1970. 35 Fed. Reg. 12330.

Clearly, the Secretary possessed the authority to promulgate this regulation. See 42 U.S.C. 1395x(v). That section grants broad authority to the Secretary to define

"reasonable cost" and he decided that "reasonable cost" did not include the cost resulting from accelerated depreciation charges, except in very limited circumstances. See also 42 U.S.C. 1302 and 1395hh.

Moreover, once the Secretary decided that accelerated methods of depreciation led to excess payments in those cases in which a provider utilizing one of those methods terminated its participation in the program prior to the expiration of the useful life of the asset, he was required to establish a means for recapturing those overpayments, Kingsbrook Jewish Medical Center v. Richardson, supra, by that section of 42 U.S.C. 1395x(v) which required him to make "suitable retroactive adjustments".

Finally, it is clear that had the Secretary not provided for the recapture of the excessive payments, he would have violated that portion of 42 U.S.C. 1395x(v) which evidenced the express intent of Congress to prevent payment by the program for services rendered to patients who are not Medicare beneficiaries.[22/]

22/ 42 U.S.C. 1395x(v) provides that the regulations defining "reasonable cost" which the Secretary is required to promulgate

> . . . shall (A) take into account both direct and indirect costs of providers of services in order that, under the method of determining costs, the costs with respect to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered with not be borne by such insurance programs. . . .

The Act does not authorize the Secretary to require providers to "fund" depreciation charges, i.e., to require reimbursement received on account of depreciation to be utilized to establish a reserve towards replacement, modernization, or expansion. See 42 U.S.C. 1395. Accordingly, the reimbursement received as a depreciation allowance by a provider may be absorbed into operating revenues and applied by providers to current operating expenses.[23/] See Hearings, supra, fn. 20, p. 21.

Insofar as providers do in fact apply the reimbursement received as the result of the use of an accelerated method of depreciation to current operating expenses, they maintain their charges to patients who are not Medicare beneficiaries at a level below that which they would be required to charge if the reimbursement had been calculated under the straight-line method. So long as the provider remains in the program, this fact does not appear to cause a problem under the Act since charges to non-Medicare beneficiaries will rise as the reimbursement for depreciation decreases. However, if the provider terminates its participation in the program early in the useful life of the asset, the reduction in reimbursement will not occur, the provider will have transferred more reimbursement to operating expenses than it would have had it used the straight-line method, and charges to

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23/ The regulations do provide an incentive to fund depreciation charges, however. 20 C.F.R. 405.415(e).

non-Medicare beneficiaries will thus have been kept lower than they would have been if the provider had utilized the straight-line method. Thus, in effect, the Medicare program, in violation of the Act, would have borne the cost of providing services to individuals not covered under the Act. See 42 U.S.C. 1395x(v).

In sum, it is clear that 20 C.F.R. 405.415(d)(3) is authorized by statute, 42 U.S.C. 1395x(v);[24/] 42 U.S.C. 1302 and 1395hh, and is reasonably related to the purpose of the program. It therefore must be upheld. See, e.g. Mourning v. Family Publications Service, Inc., 411 U.S. 356 (1973); State of Florida v. Mathews, C.A. 5, No. 75-1905, decided, January 2[illegible], 1976.

The district court implied, App. 26a-7a, that the regulation was not authorized by statute because, in its view, section 1395x(v) did not authorized a regulation which penalized a provider for terminating its participation in the program.

However, it is clear that the regulation does not penalize or focus upon termination. Rather, the regulation

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24/ Mount Sinai Hospital of Greater Miami v. Weinberger, 517 F. 2d 329 (C.A. 5, 1975), is not to the contrary. There, the question presented was whether the Medicare Act contained a statutory abrogation of the Secretary's common-law right to recoup payments made for services subsequently determined not to have been covered under the Act. Id. at 337. The Secretary contended, inter alia, that the statute not only failed to abrogate the right but expressly authorized it in 42 U.S.C. 1395g. In rejecting this contention, the Court stated that 1395g was related to 1395x(v) and that both sections were related to reasonable cost determinations (at issue here), and not the coverage determination at issue there. Id. at 335-36. The Court went on to hold, however, that the common law right had not been abrogated.

focuses upon the receipt of excessive reimbursement. This is demonstrated by the fact that another portion of the very sentence of the regulation at issue here states that the difference between the reimbursement received under the accelerated method and what would have been received had the straight-line method been utilized would be recouped even if the provider remained in the program when the Medicare portion of its allowable costs decreases to below a certain level.[25/] 20 C.F.R. 405.415(d)(2). Thus, contrary to the district court, the regulation does not focus upon termination but upon the receipt of excessive reimbursement. It does not penalize a provider for terminating its participation in the program, but rather simply requires a terminating provider to settle his account with the Secretary and return excessive reimbursements to the Secretary.

B. The regulation, as applied to Windsor is constitutional.

The district court, following what it termed the principal applied in tax cases, App. 30a, held that the Secretary's regulation was unconstitutional insofar as it was applied

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25/ The Secretary reimburses a provider only for a proportion of depreciation. For example,if an asset depreciates $1000 in a year and Medicare beneficiaries accounted for only 40% of the use of the asset during the year, the Secretary will pay the provider $400.

The purpose of the portion of the regulation noted above is designed to prevent the situation where Medicare utilization is high in the years in which, under the accelerated method, depreciation is greatest, but Medicare utilization decreases in the year when it is the lowest. In the absence of the regulation, the Secretary in these circumstances would pay more for depreciation than he would if the straight-line method had been utilized from the inception.

prior to the first day of the year in which the regulation became effective.

Assuming that the regulation can be considered "retroactive legislation", it is clear that it is not unconstitutional simply because it may be interpreted as retroactive. League v. Texas, 184 U.S. 156, 161 (1902). Moreover, it is clear that the constitutionality of the regulation depends upon a variety of factors and not upon a specific, well-settled rule. Hachman, The Supreme Court and the Constitutionality of Retroactive Legislation, 73 Harv. L. Rev. 692, 694-97 (1960). As the Supreme Court, speaking of the constitutionality of retroactive application of a tax, has stated:

> It is necessary to consider the nature of the tax and the circumstances in which it is laid before it can be said that its retroactive application is so harsh and oppressive as to transgress the constitutional limitation [imposed by the Fifth Amendment] [Welsh v. Henry, 305 U.S. 134 (1938)]

See also United States v. Hudson, 299 U.S. 498 (1937); First National Bank in Dallas v. United States, 420 F. 2d 725 (Ct. Cl. 1970).

Here, it is clear that the operation of the regulation in this case and the circumstances which led to its promulgation demonstrate that it is not so "harsh and oppressive" as to render it unconstituional.

As we explained above, the Medicare Act was a new and historic act. Experience with this type of legislation was almost non-existent. Congress therefore merely established certain broad principles which the Secretary was to follow in determining the reimbursement which was to be paid to

providers under the Act and specifcally directed him 42 U.S.C. 1395x(v), to make retroactive adjustments when, as the result of experience under the Act, he discovered that adjustments were required to protect the integrity of the program and its trust fund.

As we have also shown, the Secretary's determination to permit providers to utilize accelerated methods of depreciation was subsequently discovered to lead to excessive payments. The Secretary, in recognition of this fact, determined to permit the use only of the straight-line method (except in certain limited circumstances). However, in order to mitigate the effects of the retroactive adjustment required as a result of this subsequent determination, the Secretary determined to permit providers participating in the program and utilizing an accelerated method to continue to do so so long as they remained in the program until the expiration of the useful life of the asset. Given this fact and the fact, as explained above, that a provider which utilizes an accelerated method and which terminates its participation in the program prior to the expiration of the asset's useful life no doubt will have utilized its excessive reimbursement to maintain charges to non-Medicare beneficiaries at a lower level than they otherwise would have been, it can hardly be said that the Secretary's action was unreasonable.

Moreover, Windsor became a provider of services in July, 1967. At that time, Windsor knew or should have know that the question of the manner in which "reasonable

cost" was to be calculated was not specified in the statute. See 42 U.S.C. 1395x(v). It knew or should have know that the Secretary's decision in 1966 to permit the use of accelerated depreciation was the subject of controversy. See Hearings, supra, fn. 20. It knew or should have known that the statute specifically provided that the Secretary was required required to make "suitable retroactive adjustments" if a method of calculating "reasonable cost" was subsequently determined to result in excessive payments. 42 U.S.C. 1395x(v). Finally, it knew or should have known on February 5, 1970 -- nearly six months before the regulation became effective -- that the Secretary had proposed regulations providing for the recapture of the difference between the reimbursement received as the result of the use of an accelerated method of depreciation and the reimbursement that would have been received had the straight-line method been used if a provider terminated its participation in the program prior to the useful life of the asset. Windsor could have left the program at that time -- before the regulation became effective -- without repayment of the difference.[26/] Yet, the record is completely silent as to

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26/ For these reason, it can hardly be contended that Windsor possessed a "vested right," i.e., a "practical and substantive" right "which the Constitution was designed to preserve," Davis v. Mills, 194 U.S. 451, 457 (1904), to the reimbursement it received in excess of the amount it would have received had it utilized the straight-line method of depreciation.

whether Windsor even attempted to leave the program during this period. In sum, Windsor had every reason to be even more familiar than the ordinary businessman with the principle that "those who do business in . . . [a] regulated field cannot object if the legislative scheme is buttressed by subsequent amendments to achieve the legislative end." Federal Housing Administration v. The Darlington, Inc., 358 U.S. 84, 91 (1958). Cf. Norman v. Baltimore & Ohio R. R. Co., 294 U.S. 240, 307-308 (1935); Vieux v. Sixth Ward Ass'n., 310 U.S. 32, 38 (1940).

In addition, it should be noted that the regulation does not operate so as to deprive Windsor of the reimbursement to which it is entitled. The Medicare Act specifically provides that proprietary nursing homes should receive a reasonable return on equity capital (i.e., profit) as part of the "reasonable cost" for which they are reimbursed 42 U.S.C. 1395x(v)(1). The Secretary's regulations provide for such an allowance both for skilled nursing homes and proprietary hospitals. 20 C.F.R. 404.429. When, under the regulation at issue, the difference between the depreciation received utilizing the accelerated method and the depreciation which would have been received had the straight-line method been used is calculated, the basis of the asset is adjusted as if the straight-line method had been utilized. Using this new basis, which is higher than the basis under the accelerated method, the allowance for a return on equity capital is also recalculated, i.e., increased, and then

subtracted from the overpayment due to excessive depreciation. See 20 C.F.R. 405.415(d)(2). Thus, the amount recouped from providers such as Windsor represents a net amount, not an absolute amount.

In conclusion, it can hardly be said that the Secretary's regulation is so "harsh and oppressive," so "unreasonable," as to violate the Constitution. E.g., Federal Housing Administration v. The Darlington, Inc., supra; Milliken v. United States, 283 U.S. 15, 22-24 (1931); Lichter v. United States, 334 U.S. 742 (1948); Blanchard v. Reconstruction Finance Corp., 177 F. 2d 727, 729-730 (C.A.D.C., 194[illegible]), certiorari denied, 339 U.S. 912. Cf. Norman v. Baltimore Ohio R. R. Co., supra; Vieux v. Sixth Ward Ass'n., supra.

CONCLUSION

For the foregoing reason, the decision of the district court should be reversed.

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CERTIFICATE OF SERVICE

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